

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5 Filed 221 10-31-57 et  
**CERTIFICATE OF DEATH**

11121

11125

Reg. Dist. No.

261

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mason</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mason Md</u>	
c. LENGTH OF STAY IN TB <u>Life</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RH W</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kate</u> Middle <u>B.</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>5</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR: Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Elijah S Ward</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. George Ward Mason</u>		Address <u>md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Remia, Acute Dil of heart -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis C Int Nephritis</u> DUE TO <u>General Arteriosclerosis</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>57</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1, 1957</u> to <u>Oct 5, 1957</u> , that I last saw the deceased alive on <u>Oct 4, 1957</u> , and that death occurred at <u>12:00 M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George C. Boulbourn</u> M.D. <u>Marion Sta. Md</u>		DATE SIGNED <u>10-6-57</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE C. BOULBOURN-MD</u> <u>MARION STATION MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Oct 7 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Mason Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE (Print name) <u>James Herman Crawford</u>		ADDRESS <u>Md</u>	
24. REC'D BY REGISTRAR <u>10-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Willie K. Payne</u>	

CERTIFICATE OF DEATH

OCT 10 1957

RECEIVED

BUREAU OF HEALTH

11122

## CERTIFICATE OF DEATH

Reg. Dist. No.

760

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Eden R.F.D.</b>				c. LENGTH OF STAY IN 1b <b>68 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Eden R.F.D. X0</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Major</b> Middle <b>Lee</b> Last <b>Cathell</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23, 1888</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles A. Cathell</b>				14. MOTHER'S MAIDEN NAME <b>Mary F. William</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Lula Lee Fields</b> Address <b>Eden, Md. R.F.D.</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>241X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial Asthma</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>1945</b> , 19____, to <b>death</b> , 19____, that I last saw the deceased alive on <b>10-16-57</b> , and that death occurred at <b>10:00 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>L. L. Lowrey</b> M.D. <b>Frederick Md.</b> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10-19-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Allen cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Allen, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Wilson</b> ADDRESS <b>Princess Anne, Md.</b>				24. REC'D BY REGISTRAR <b>Oct 21 1957</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Dr. R. H. Johnson</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Dec. 1957  
58 years  
Male  
White  
Married  
Residence: Baltimore, Maryland  
Cause of Death: ...  
Date of Death: ...  
Place of Death: ...  
Signature: ...  
Physician: ...

*Charles A. ...*  
*Resident Physician*

BUREAU V. 1

101 21 1957

RECEIVED

11123

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 261-

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield Marion - all life</b>		c. LENGTH OF STAY IN 1b <b>Crisfield Marion -</b>	
III. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Orie</b> Middle <b>Lee</b> Last <b>Collins</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>27</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1957</b>
9. AGE (In years last birthday) <b>1 2</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Crisfield</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ralph Collins</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Cottman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Ralph Collins Marion Sta. MD #72</b>	
17. INFORMANT Address <b>Ralph Collins Marion Sta. MD #72</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>499X Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>William H. Coulbourn</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Oct. 29, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Family Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Sta., MD. Som. Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b>		ADDRESS <b>Marion Sta. MD.</b>	
24. REC'D BY REGISTRAR <b>DATE 10-28-57</b>		24b. REGISTRAR'S SIGNATURE <b>Nellie D. Payne</b>	

2079215 XV6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



24-11-1967

Christie/9  
MT

Christie  
Jensen

Oct. 27 72

Lea Collins  
Sept. 24 1927

What do you think?

St. 24.

Christie

Rec'd 19/10/55

Right Collins

Ralph Collins  
March 28, 1975

Ammonia

~~BUREAU~~ 4 31

1967

RECEIVED - 58-25

Charles H. Ward - Marion St. Mt.  
Burial Oct. 28, 1894 Family Cemetery Marion St. Mt. Cem. Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11124

## CERTIFICATE OF DEATH

11129

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>			
c. LENGTH OF STAY IN 1b <b>Lifetime</b>				d. STREET ADDRESS <b>R.F.D.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D.</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>VIRGINIA</b> Middle <b>CATHERINE</b> Last <b>DIZE</b>				4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1866</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>11</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Albert Parker</b>				14. MOTHER'S MAIDEN NAME <b>Ada Hickman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Furman Dize--R.F.D. Crisfield, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO <b>1 mo</b> (c) <b>Hypertension</b> <b>1 yr - x</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Failure - Arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>Sept. 1</b> , 1957, to <b>Oct. 29</b> , 1957, that I last saw the deceased alive on <b>Oct. 29</b> , 1957, and that death occurred at <b>11:40 P.M.</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Main St.--Crisfield, Maryland</b>				DATE SIGNED <b>10/30/57</b>			
ACTUAL SIGNATURE <b>Sarah M. Peyton</b>		M.D. <b>Crisfield, Md.</b>					
PHYSICIAN'S NAME (Type) <b>Sarah M. Peyton, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 1, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Marion, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR <b>10/31/57</b>		24b. REGISTRAR'S SIGNATURE <b>Barbara L. Nelson</b>	

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 12 1957

RECEIVED



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11125

11130

11125

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crisfield</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crisfield x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>McCready Memorial</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>May</u> Middle <u>M.</u> Last <u>Garrison</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 13, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin W. Nelson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Blizard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Guy Garrison R.T. Crisfield Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Ischemic Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension &amp; Comp. ma</u> DUE TO (c) <u>Diabetic Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>3 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peripheral Vascular Disease - Refracted blood</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>57</u> , to <u>Oct 23</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Oct 23</u> , 19 <u>57</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah M. Peyton</u> M.D. <u>Crisfield Md</u>		DATE SIGNED <u>10/25/57</u>	
PHYSICIAN'S NAME (Type) <u>Sarah M. Peyton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
<u>burial</u>	<u>10/26/57</u>	<u>St Paul's</u>	<u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Hannon</u>		ADDRESS <u>Crisfield Md.</u>	24a. REC'D BY REGISTRAR DATE <u>10/31/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Burton S. Hannon</u>	

# CERTIFICATE OF DEATH

BUREAU V. 3

NOV 12 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11131

## 11126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D.</b>		d. STREET ADDRESS <b>R.F.D. Box 264</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES EDWARD HORSEY</b>		4. DATE OF DEATH Month Day Year <b>October 27 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1903</b>
9. AGE (In years last birthday) <b>49 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Samuel H. Horsey</b>		14. MOTHER'S MAIDEN NAME <b>Cora Laws</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W W II</b>		16. SOCIAL SECURITY NO <b>219-09-0556</b>	
17. INFORMANT <b>Mrs. Cora L. Horsey--R.F.D.--Crisfield, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure - Exposure</b> <b>795.3</b> DUE TO (b) <b>Found Dead on Side of Road</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Rainy Night</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>William H. Coulbourn, M.D.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part II of Item 18) <b>William H. Coulbourn, M.D.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>DEPUTY MEDICAL EXAMINER FOR SOMERSET COUNTY, MD.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W. H. Coulbourn</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William H. Coulbourn, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 30, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11/7/57</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Coulbourn</b>		DATE SIGNED <b>Nov 1st 1957</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11117

CERTIFICATE OF DEATH

111325  
 Reg. Dist. No. 365

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Christfield</u>		c. LENGTH OF STAY IN 1b <u>1 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Christfield</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>At Home</u>				f. STREET ADDRESS <u>Asbury Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>SALLIE</u> First <u>E.</u> Middle <u>LAWSON</u> Last				A. DATE OF DEATH <u>OCT.</u> Month <u>15</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 7 - 1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Christfield Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE W. LAWSON</u>		14. MOTHER'S MAIDEN NAME <u>MARIA WHITTINGTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Mrs Paul Maddix Christfield Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 4, 1947</u> to <u>Oct 15, 1957</u> , that I last saw the deceased alive on <u>Oct 15, 1957</u> , and that death occurred at <u>Christfield, Md.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. R. Cawley</u> M.D.		ADDRESS (Street, city or town, state) <u>Christfield, Md.</u>		DATE SIGNED <u>10/18/57</u>			
PHYSICIAN'S NAME (Type) <u>C. R. Cawley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>10/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury ME</u>		22d. LOCATION (City, town, county) (State) <u>Christfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. R. Webster</u> ADDRESS <u>Christfield Md</u>				24a. REC'D BY REGISTRAR <u>DATE 10/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>Bertie S. Adams</u>	



RECEIVED

OCT 31 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN, a. The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician. b. This certificate has been signed by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Sec. 5, Art. 27, et

## CERTIFICATE OF DEATH

Reg. Dist. No.

11127

11133-265-

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cristfield</b>		c. LENGTH OF STAY IN 1b <b>Infant</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>McCready Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First <b>Infant</b> Middle <b>Maddox</b> Last <b>Maddox</b>		4. DATE OF DEATH Month <b>10</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 11, 1957</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cristfield, U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carroll Hall Jr.</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Maddox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Mrs. Sophia Maddox-Marion Sta., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>6 mos. pregnancy - premature -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 11, 1957</b> , to <b>Oct 12, 1957</b> , that I last saw the deceased alive on <b>Oct 11, 1957</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George C. Coulbourn</b> M.D.		ADDRESS (Street, city or town, state) <b>Marion Sta., Md.</b> DATE SIGNED <b>10-12-57</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE C. COULBOURN, MD</b>		<b>Marion Station - Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>10/13/57</b>	22c. NAME OF CEMETERY <b>Family Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Marion Sta., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Ward</b>		ADDRESS <b>Marion Sta., Md.</b>	
24a. REC'D BY REGISTRAR <b>10-12-57</b>		24b. REGISTRAR'S SIGNATURE <b>Nellie B. Payne</b>	

BUREAU V. B.

OCT 16 1957

RECEIVED

Charles H. Ward - Marion 245-1119  
10/18/57 Family Cemetery - Marion, Mo.

Mr. Joseph H. Ward - Marion 245-1119  
Virginia H. Ward  
Mr. George H. Ward - Marion 245-1119  
Negro  
Garroll Hall  
that  
McGee's Hospital  
Cristall  
the first  
1119

11128

CERTIFICATE OF DEATH

Reg. Dist. No. 205

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b>				c. LENGTH OF STAY IN TB <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McCready Hospital</b>				e. STREET ADDRESS <b>Main St., Ext.</b>			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ELISHA</b> Middle <b>K.</b> Last <b>STERLING</b>				4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 7, 1896</b>	
9. AGE (In years last birthday) <b>61</b> yrs		IF UNDER 1 YEAR: Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood Industry</b>		11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>William H. Sterling</b>				14. MOTHER'S MAIDEN NAME <b>Almira Adams</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <b>W W I</b> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO <b>216-09-0114</b>		17. INFORMANT Address <b>Mrs. Carrie Sterling—Main St., Ext. Crisfield, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Atherosclerosis</b> DUE TO (c) <b>Unknown</b>				INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchial Catheter with Emphysema</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. <b></b> p. m. <b></b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>8/25</b> , 19 <b>52</b> to <b>10/30</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10/24</b> , 19 <b>57</b> , and that death occurred at <b>7:15 A</b> .M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main St., Crisfield, Md.</b> DATE SIGNED <b>10/30/57</b>							
ACTUAL SIGNATURE <b>A. N. Barr</b>				M.D. <b>Main St., Crisfield, Md.</b>			
PHYSICIAN'S NAME (Type) <b>A. N. Barr, M. D.</b>				Main St.--Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 31, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lawsonia Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons--Crisfield, Md.</b>				24a. REC'D BY REGISTRAR <b>10/31/57</b>		24b. REGISTRAR'S SIGNATURE <b>Richard J. ...</b>	

BUREAU V. S.

NOV 12 1957

RECEIVED



11118

CERTIFICATE OF DEATH

11136

Reg. Dist. No. 265

1 PLACE OF DEATH a. COUNTY Somerset MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvary Section				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last WILLIE CATHERINE STERLING				4. DATE OF DEATH Month Day Year October 21, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 16, 1871	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Littleton Milbourne				14. MOTHER'S MAIDEN NAME Margaret Beauchamp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO None			
17. INFORMANT Address Gordon C. Sterling, Crisfield, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO							
(b) Generalized Enteritis DUE TO							
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 21, 1957, to Oct 21, 1957, that I last saw the deceased alive on Oct 21, 1957, and that death occurred at 9:00 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE A. N. Barr, M.D.				DATE SIGNED 10/23/57			
PHYSICIAN'S NAME (Type) A. N. Barr, M. D.				Crisfield, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-24-57		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bradshaw & Sons, Crisfield, Maryland				24a. REC'D BY REGISTRAR DATE 10/31/57		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 12 1957

BUREAU V. S.

CERTIFICATE OF DEATH

11137  
Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
c. LENGTH OF STAY IN 1b Lifetime		d. STREET ADDRESS 49 Chesapeake Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 49 Chesapeake Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last FLETCHER SWIFT		4. DATE OF DEATH Month October Day 26 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1884
9. AGE (In years last birthday) 73		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Emp loyee		10b. KIND OF BUSINESS OR INDUSTRY City of Crisfield	
11. BIRTHPLACE (State or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jeff Swift		14. MOTHER'S MAIDEN NAME Anna Bethards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Sarah Swift-49 Chesapeake Ave.-Crisfield, Md.		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1955, to Oct 26 1957, that I last saw the deceased alive on Oct 26 1957, and that death occurred at 5:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. N. Barr M.D.		ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 10/25/57	
PHYSICIAN'S NAME (Type) A. N. Barr, M. D.		Main St.-Crisfield, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 29, 1957	22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery	22d. LOCATION (C'ty, town, or county) (State) Crisfield, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.		24a. REC'D BY REGISTRAR DATE 10/31/57 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 12 1957

BUREAU V. S.

11120

## CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) b. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			
c. LENGTH OF STAY IN 1b Lifetime				d. STREET ADDRESS 3 South Somerset Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 South Somerset Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ADALINE Middle BLANCHE Last TAWES				4. DATE OF DEATH Month October Day 8 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 13, 1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Washington S. Croswell				14. MOTHER'S MAIDEN NAME Julia Ann Potter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Address Mrs. Adaline Hill-3 S. Somerset Ave.-Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 hours 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 13, 1953, to Oct. 8, 1957, that I last saw the deceased alive on Oct. 8, 1957, and that death occurred at 5:00 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Sarah M. Peyton M.D.				ADDRESS (Street, city or town, state) Crisfield, Md.			
DATE SIGNED 10/31/57							
PHYSICIAN'S NAME (Type) Dr. Sarah M. Peyton, M.D.				Main St.--Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1957		22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons--Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 10/31/57		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

NOV 12 1957

BUREAU V. S.

Somerset

RURAL and give nearest town)

Rural Marion Station

d. STREET ADDRESS

• IS RESIDENCE  
ON A FARM?  
YES ☐ NO ☐

Day	Year
10	

IF UNDER 1 YEAR	IF UNDER 24 HRS
-----------------	-----------------

12. CITIZEN OF WHAT COUNTRY?

Ide Brown

Address \_\_\_\_\_

Ira F. Taylor--R.F.D. Marion Station. Md.

Lympho-sarcoma

6740

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

204. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Oct-1, 1957 to Oct-1, 1957, that I last saw the deceased alive on 10-1, 1957, and that death occurred at 5:05 P.M., from the causes and on the date stated above.

CPR answer

**ADDRESS** (Street, city or town, state)

DATE SIGNED \_\_\_\_\_

Dr. C. G. Rawley, M. D.

Main St.--Crisfield, Md.

22d. LOCATION (City, town, or county)  
Marion Station, Md.

(State)

ADDRESS \_\_\_\_\_

24a REC'D BY REGISTRAR

24b REGISTRAR'S SIGNATURE

Bradshaw & Sons—Crisfield, Md.

DATE 10/18/57

Boston, June 1864

CERTIFICATE OF DEATH

FILE NO.

**RECEIVED**  
OCT 21 1957  
BUREAU V. R.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11140

Reg. Dist. No.

11130

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Somerset</b> <span style="float: right;">MARYLAND</span>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> b. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>		c. LENGTH OF STAY IN 1b <b>Minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>On Street in Town (In Truck)</b>		d. STREET ADDRESS <b>810 S. Division St</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>ELLIOTT</b> Last <b>TAYLOR</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>26</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1917</b>
9. AGE (in years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee (Shirt Factory)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Machinist</b>	
11. BIRTHPLACE (State or foreign country) <b>Westover, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Ernest G. Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Virgie Dorsey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>716-01-7017</b>	
17. INFORMANT <b>Mrs. Alma Hammond Taylor (Wife) 810 S. Division St. Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b></b> a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. H. Johnson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. R. H. Johnson</b>		DATE SIGNED <b>October 28th 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 29, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY FUNERAL HOME - SALISBURY, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 10/28/57</b>	24b. REGISTRAR'S SIGNATURE <b>R. H. Johnson</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
OCT 30 1957  
BUREAU V. 3

7

RECEIVED  
OCT 30 1957  
BUREAU V. 3